CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	45t	£ 2124)	/13	FORM	APPROVED . 0938-0391
STATEMENT AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BU/LD	TIPLE CONSTRUCTION /		(X3) DATE SI COMPLE	URVEY
		445277	B. WING			01/1	0/2013
NAMEOFF	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
MCMINN	 	G HOME & REHAB CENTER		886 HWY 411 NORTH ETOWAH, TN 37331			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTION CROSS-REFERENCE	AN OF CORRECT VE ACTION SHOU ED TO THE APPRO ICIENCY)	ILO BE	(X5) COMPLETION DATE
SS=D	consult with the resistance, notify the resistance or an interested fair accident involving the injury and has the pure injury and has the resident of the resident from the \$483.12(a). The facility must also and, if known, the resident from the resident room or respective in \$483.15 and, if known, the resident rights under regulations as specified in \$483.15 and and a section. The facility must receive and phose in representative of the resident rights and phose in representative of the section. The facility must receive and phose in representative of the section in the resident rights and phose in representative of the section in the resident rights.	diately inform the resident; ident's physician; and if sident's legal representative nily member when there is an a resident which results in otential for requiring physician ficant change in the resident's psychosocial status (i.e., a th, mental, or psychosocial nreatening conditions or s); a need to alter treatment need to discontinue an attent due to adverse a commence a new form of sion to transfer or discharge a facility as specified in a promptly notify the resident sident's legal representative number when there is a commate assignment as side(e)(2); or a change in Federal or State law or fied in paragraph (b)(1) of the ord and periodically update ne number of the resident's or interested family member. It is not met as evidenced accord review, review of facility the facility falled to notify the	F 15	Programling andles ave	cution of this p agreement by it This response is ission of fault by other individuals this response a correction is su	ne provider also not to the facility, as who draft and plan of braitted as	
BORATORY I		RUSHPPLIER REPRESENTATIVE'S SIGNA	TURE	1 1 TITLE			KB) DATE
	robert 131	blaker	No	A. administra	for	2/4/	2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the pattents. (See instructions.) Except for nursing homes, the findings stated above are disclosable 80 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013 FORM APPROVED

STATEMEN	T OF DEFICIENCIES	WILL PROVIDE SERVICES				OMB NO	<u>), 0938-0391</u>
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TPLE CONSTRUCTION	(X3) DATE 5 COMPL	
NAME OF 1	PROVIDER OR SUPPLIER	445277	B. WI	NG_		01/1	10/2013
		G HOME & REHAB CENTER		8	REET ADDRESS, CITY, STATE, ZIP CODE 886 HWY 411 NORTH ETOWAH, TN 37331		· · · ·
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	therapeutic range for thirty-seven resident thirty-seven resident. The findings include Resident #38 was as September 9, 2008, 2012, with diagnose Failure, Pleural Effus Pulmonary Disease. Medical record review Normalization Ratio clotting) dated Deceid 23.0 (normal range frange .80-1.20). Medical record review December 24, 2012, results to DR. (docto Medical record review December 26, 2012, "Order for Coumad (Saturday), Tue (Tuemg all other days" Medical record review December 30, 2012, 3.9. Medical record review December 31, 2012, DR"	ory results exceeding or one resident (#36) of its reviewed. d: dmitted to the facility on and readmitted on April 9, sincluding Chronic Renalsion, and Chronic Obstructive w of a Protime/International (PT/INR) (lab test for blood mber 24, 2012, revealed PT 10-13), and INR 3.0 (normal w of a Nurse's Note dated revealed "faxed Protime r)" w of a Nurse's Note dated at 3:30 p.m., revealed in 2 mg (milligrams) Sat sday), Thur (Thursday), 4 v of a PT/INR dated revealed PT 26.4 and INR v of a Nurse's Note dated revealed PT 26.4 and INR	F	157	1) A PT/INR was completed for R #36 on 1/7/2013. The physician was notified promptly upon receiving the first promptly upon receiving the therapeutic range. 2) The facility has determined the residents taking Coumadin therapithe potential to be affected. 3) LPN #1 was counseled on 1/8/4 the DON addressing the circumstate that require notification of the residents. This included notification holidays and off hours. All charge responsible for medication administration and the currently working have been indiviruated about notification of the resident's physician, legal represe or family member including notification from the sident's physician, legal represe or family member including notification of changes will be concept the DON on 2/5/2013 and 2/6/2 all licensed nurses PRN nurses and medical leave will be in-serviced eturning to work. 4) The DON or designee, will concept the DON or designee, will concept the property evaluated and communicated to the appropriate physicians and families). The plant correction will be monitored at the quarterly PI/QA meeting until such the property and the property and the property evaluated and communicated to the appropriate physicians and families). The plant correction will be monitored at the quarterly PI/QA meeting until such the property and the property and the property evaluated and consistent substantial compliance is the property and the property	vas ne results s within at all y had 2013 by ances dent's family during nurses stration dually e ntative ation de those d before duct a veekly ese been eople of time	2/8/2013
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	- fam anti imalona anisting Ot	solete Event ID: IP6T11		Facil	ity ID: TN5403 If conlinu	ation sheet	Page 2 of 28

FOR

Robert BPolsham

If conlinuation sheet Page 2 of 26

02:47:17 p.m. 02-04-2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES.

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

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		445277	B. WING			01/10/2013	
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZII		
MCMINN	MEMORIAL NURSIN	G HOME & REHAB CENTER			WY 411 NORTH VAH, TN 37331		
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	January 1, 2013, (Note of the rest of the	ary 31, 2013, revealed on MONDAY) Cournadin 4 mg had esident. ew of a Nurse's Note dated vealed "orders received for and frequency. Hold) 2 doses 1/2/13 and 1/3/13. enday), W (Wednesday), F T (Tuesday), TH (Thursday),	F1	57	DETICIEN		
F 241 SS=D	Interview with the Di 8, 2013, at 4:00 p.m Station, confirmed II Physician of a lab re therapeutic range fo 483.15(a) DIGNITY INDIVIDUALITY	r two days.	F 2	41			
ORM CMS-256	67(02-99) Previous Versions (Disolete Event ID: IPST 11		Facility ID	:TN5403	If continuation sher	al Page 3 of 25

Facility ID: TN5403

If continuation sheet Page 3 of 26

Robut Blobson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLANOF CORRECTION A BULDING 445277 NAME OF PROVIDER OR SUPPLIER MCMINN MEMORIAL NURSING HOME & REHAB CENTER SIMMARY STATEMENT OF DEFICIENCES SURVAY, THE TOWARY, THE TOWARD OF DEFICIENCES SURVAY, THE TOWARY OR SUPPLIER FOR PREFIX TAG. F. 2411 Continued From page 3 manner and in an environment that maintains or enhances each resident's dignly and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain resident dignly from one residents evidenced. The findings included: Resident #27 was admitted to the facility on April 15, 2003, and readmitted on November 15, 2010, with diagnoses including Bybolar Affective Disorder and Confusion. Chesenvation on January 7, 2013, at 12:05 p.m., in the dining room, revealed the resident stitting in a wheelchair at the table with three other residents. Further observation at this time revealed the other residents ealing lunch. Chesenvation on January 7, 2013, at 12:30 p.m., in the dining room, revealed the resident was served after all other residents in the dining room and the resident was served after all other residents in the dining room and the resident was served after all other residents in the dining room in the dining room in the dining room, revealed the resident was served after all other residents in the dining room in the dining room, revealed the resident was served after all other residents in the dining room because the resident was served after all other residents in the dining room because the resident was served after all other residents was served after all other residents in the dining room because the resident was served after all other residents in the dining room because the resident was served after all other residents was served after all other residents in the dining room because the resident was served after all other residents with the dining room because the resident e	STATEMENT	STATISTICS OF PROPERTY OF PROP					OMB NO	. 0938-0391
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MCMINN MEMORIAL NURSING HOME & REHAB CENTER IXA) D SUMMARY STATEMENT OF DEPICIPACES (EACH DEFICIENCY MUST BE FREGEDED BY FILL, TAGE F 241 Continued From page 3 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This RECUIREMENT is not met as evidenced by. Based on medical record review, observation, and interview, the facility failed to maintain resident dignity or one resident's (#27) during meal time of thirty-seven resident's reviewed. The findings included: Resident #27 was admitted to the facility on April 15, 2003, and readmitted on November 15, 2010, with diagnoses including Blocher Affective Disorder and Confusion. Observation on January 7, 2013, at 12:05 p.m., in the dining room, revealed the resident stilling in a wheelchair at the table with three other residents. Further observation at this time revealed the other resident #27 a lunch tray, Further observation at this time revealed the other resident may 2013, at 12:35 p.m., revealed the resident was served after all other residents in the dining room, revealed the resident season because the resident was served after all other resident in the dining room, revealed the resident season because the resident was served after all other residents in the dining room revealed the resident was served after all other residents in the dining room revealed the resident was served after all other residents in the dining room revealed the resident was served after all other residents in the dining room revealed was served after all other residents in the dining room revealed the resident was served after all other residents in the dining room revealed the resident was served after all other residents in the dining room revealed the resident was served after all other residents in the dining room reports and validation checklists will be completed by 28/2013 on all amployees currently working. The checklist will be reviewed by the PICAC Committee (auch was a proposit			445277	B. WI	VG _	· · · · · · · · · · · · · · · · · · ·	61/4	0/2013
MCMINN MEMORIAL NURSING HOME & REHAB CENTER Sest HWY 41 NORTH ETOWAH, TN 37331	NAME OF I	PROVIDER OR SUPPLIER			CTI	DEST ADDRESS AFTE OTHER DESCRIPTION	<u> </u>	012013
PREFIX TAG SUMMARY STATEMENT OF DESCRIBENCES (EACH DESCRIBENCE WIST BE RECEDED BY ILL. REGULATORY OR LSC IDENTIFYING INFORMATION) F241 Continued From page 3 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain resident dignity for one resident's reviewed. The findings included: The findings included: Resident #27 was admitted to the facility on April 15, 2003, and readmitted on November 15, 2010, with diagnoses including Bipolar Affective Disorder and Confusion. Observation on January 7, 2013, at 12:30 p.m., in the dining room, revealed the resident will be completed on PEN employees and other residents eating lunch. Observation on Jenuary 7, 2013, at 12:30 p.m., in the dining room, revealed Certified Nurse Aide (CNA) #1 served resident #27 a lunch tray. Further observation at this time revealed the other residents at the revealed CNA #1 set down and began feeding the resident. Interview with CNA #1 on January 7, 2013, at 12:30 p.m., revealed the resident is served after all other residents in the dining room because the resident required assistance to eat. Interview with CNA #1 on January 7, 2013, at 12:30 p.m., in the dining room revealed the resident is served after all other resident is not feeling room because the resident required assistance to a set. Interview with CNA #1 on January 7, 2013, at 12:30 p.m., in the PICA Committee (aurently and will be reviewed by the PICA Committee (aurently until such time consistent swith the Director of Nursing (DON) on the proper procedures removed the resident direction of Nursing (DON) on the conducted on the proper procedures for assisting resident in the direction of Nursing (DON) on the conducted on the proper procedures for assisting resident in the direction of Nursing (DON) on the conducted on the proper procedures for assisting r	MCMINN	I MEMORIAL NURSING	G HOME & REHAB CENTER		8	IB6 HWY 411 NORTH		
F241 Continued From page 3 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by. Based on medical record review, observation, and interview, the facility failed to maintain resident dignity for one resident (#27) during meet lime of thirty-seven residents reviewed. The findings included: Resident #27 was admitted to the facility on April 15, 2003, and readmitted on November 15, 2010, with diagnoses including Bipolar Affective Disorder and Confusion. Observation on January 7, 2013, at 12:05 p.m., in the dining room, revealed Certified Nurse Aide (CNA) #1 served resident #27 a lunch tray. Frurther observation at this time revealed the other residents eating bunch. Observation on January 7, 2013, at 12:30 p.m., in the dining room, revealed Certified Nurse Aide (CNA) #1 served resident #27 a lunch tray. First NAS Involved were immediately inserviced on the proper procedures for maintaining resident dignity during meal times have the potential to be affected by this practice. 3) CNAs and other facility personnel involved in providing feeding assistance to residents have been reducated on the proper procedures for assisting residents with meals to ensure resident dignity is maintained during mealtimes. Chase and other facility personnel involved the proper procedures for mealthening residents all residents have been reducated on the proper procedures for assistance to decimal file of the proper procedures for mealthing residents all residents have been reducated on the proper procedures for assistance to decimal file of the proper procedures for assistance to decimal file of the proper procedures for assistance to decimal file of the proper procedures for assistance to decimal file of the proper procedures for assistance to decimal file of the proper procedures for assistance to the proper procedures for assistance to decimal file of the proper procedures for assistance to the p	(MALID	CINGIADVETA				<u> </u>		
manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain resident dignity for one resident (#27) during meat time of thirty-seven residents reviewed. The findings included: Resident #27 was admitted to the facility on April 15, 2003, and readmitted on November 15, 2010, with diagnoses including Bipolar Affective Disorder and Confusion. Observation on January 7, 2013, at 12:05 p.m., in the dining room, revealed the residents. Further observation at this time revealed the other residents eating lunch. Observation on January 7, 2013, at 12:30 p.m., in the dining room, revealed Certified Nurse Aide (CNA) #1 service residents with tree other residents. Further observation at this time revealed CNA#1 set down and began feeding the resident. Interview with CNA#1 on January 7, 2013, at 12:35 p.m., revealed the resident was served after all other residents in the dining room because the resident required assistance to a set. Interview with the Director of Nursing CNA #1 service on the proper procedures of the proper procedures of the proper procedures of the proper procedures of the saffect by this practice. 3) CNAs and other facility personnel involved in providing feeding assistance to residents have been resetdent dignity is maintained during mealtimes. A mandatory formal in-service on dignity during meal times have the potential to be affected by this practice. 3) CNAs and other facility personnel involved in providing feeding assistance to residents with meals to ensure resident stay be involved in providing feeding assistance to residents with meals to ensure resident dignity during meal times have the potential to be affected by this practice. 3) CNAs and other facility personnel involved in providing feeding assistance to resident save bene adulation. 5, 2013 for all employees. A "Valid	PREFIX	I (EACH DEFICIENCY	MUST BE PRECEDED BY FIRE	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE OPRIATE	COMPLETION DATE
Interview with the Director of Nursing (DON) on January 7, 2013, at 3:00 p.m., in the BWing		Continued From page manner and in an erenhances each resident recognition of his passed on medical read interview, the faresident dignity for outime of thirty-seven resident #27 was accepted to the findings included Resident #27 was accepted to the findings included Resident #27 was accepted to the findings included Resident #27 was accepted to the finding room, reversided to the finding room, revealed the finding room, r	ge 3 Invironment that maintains or dent's dignity and respect in a or her individuality. T is not met as evidenced ecord review, observation, cility failed to maintain ne resident (#27) during meal esidents reviewed. Individuality on April litted to the facility on April litted on November 15, 2010, ding Bipolar Affective ion. ary 7, 2013, at 12:05 p.m., in ealed the resident sitting in a le with three other residents. It this time revealed the glunch. ary 7, 2013, at 12:30 p.m., in aled Certified Nurse Aide dent #27 a lunch tray. It this time revealed CNA #1 feeding the resident. I on January 7, 2013, at the resident was served is in the dining room.		241	I) The CNAs involved were imme serviced on the proper procedural maintaining resident dignity mealtimes. 2) The facility has determined residents requiring feeding assisted times have the potential affected by this practice. 3) CNAs and other facility involved in providing feeding assisted the proper procedures for assisting with meals to ensure resident of maintained during mealtimes. A more maintained during mealtimes will be conducted on February 2013 for all employees. A "Nother completed by 2/8/2013 for all employees. A "Nother maintained during mealtine in the procedure correctly be completed by 2/8/2013 for all employees currently working. The will be completed by 2/8/2013 for designee, will conduct observations of staff during mealting in enext three (3) months to ensure promoting and maintaining lighty during mealtimes in account our facility's practice guideling and requirements. Observations of contractions of staff during mealting lighty during mealtimes in account our facility's practice guideling and maintaining lighty during mealtimes. Observations of staff during mealting lighty during mealtimes in account of the procedure country requirements.	diately indures for during that all stance at all to be personnel stance to don the residents dignity is pandatory ing meal ary 5 and vill on all checklist returning s (DNS), randomnes over ure staff resident ordance nes and ervation	2/8/2013
		because the resident Interview with the Dire	required assistance to eat.		re Qi Si	eviewed by the PI/QA Co uarterly until such time co ubstantial compliance has been a	mmittee	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:1P6T11

Fecility ID: TN5403

If continuation sheet Page 4 of 26

Robert BPolalian

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

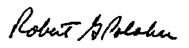
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	PROVIDER OR SUPPLIER MEMORIAL NURSIN	G HOME & REHAB CENTER	_	TREET ADDRESS, CITY, STATE, ZIP COD 886 HWY 411 NORTH ETOWAH, TN 37331	E		
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	last while the reside eating had not main 483.15(g)(1) PROV RELATED SOCIAL. The facility must proservices to attain or practicable physical well-being of each resident physical mand interview, the faservices adequate to resident (#95) of this The findings include Resident #95 was an August 18, 2012, with Malnutrition, General Depression. Medical record reviewed by the Brief Interviewed the resident on the Brief Interviewed that occurred the resident control that occurred the main and the prosident record reviewed the resident control that occurred the record reviewed the resident control that occurred the record reviewed the record revi	infirmed serving the resident on viewed other residents tained the resident's dignity. ISION OF MEDICALLY SERVICE ovide medically-related social maintain the highest mental, and psychosocial esident. IT is not met as evidenced ecord review, observation, icility failed to provide social or meet the needs of one rity-seven residents reviewed. It is not met as evidenced ecord review, observation, icility failed to provide social or meet the needs of one rity-seven residents reviewed. It is not met as evidenced ecord review, observation, icility failed to provide social or meet the needs of one rity-seven residents reviewed. It is not met as evidenced ecord review, observation, icility failed to provide social or meet the needs of one rity-seven residents reviewed. It is not met as evidenced ecord review, observation, icility failed to provide social or meet the needs of one rity-seven residents reviewed. It is not met as evidenced ecord review, observation, icility failed to provide social ecord review, obse	F 24	11	pression that the ing and she ave the spractice, emented a all residents the MDS and/ al worker or or luation and a ocial worker ent's sing will be fre social the each termine if the intions and/or tes. This vill be shared tory in- ekly update dents who assion on ement that MDS te	2/8/2013	
	expressed more dep the Dr. (doctor)"	pressed ask nursing to notify	<u>.</u>	for compliance with social wor up.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IP6T11

Facility (D: TN5403

If continuation sheet Page 5 of 26



02:48:22 p.m.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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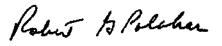
CENTERS FOR MEDICARE & MEDICARD SERVICES					CIND MO.	0830-0381		
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445277	B. WI	NG_	·	01/10/2013		
	ROVIDER OR SUPPLIER MEMORIAL NURSIN	G HOME & REHAB CENTER	<u> </u>	B	REET ADDRESS, CITY, STATE, ZIP CODE 86 HWY 411 NORTH TOWAH, TN 37331	•		
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F 250	January 9, 2013, at	locial Service Director on 12:35 p.m., in the Social	F	250				
F 279 SS=E	Director had not fol regarding the incre	k)(1) DEVELOP	F	279		:		
		the results of the assessment and revise the resident's n of care.						
	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care sent that includes measurable stables to meet a resident's and mental and psychosocial stiffed in the comprehensive						
	to be furnished to a highest practicable psychosocial well-b §483.25; and any see required under (due to the resident)	t describe the services that are altain or maintain the resident's physical, mental, and seing as required under ervices that would otherwise \$483.25 but are not provided a exercise of rights under the right to refuse treatment.						
-	by: Based on medical and interview, the f	NT is not met as evidenced record review, observation, acility falled to develop a care hts (#82, #60) for activities,						

FORM CMS-2567(02-99) Previous Versions Obsulate

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Facility ID: TN5403

If continuation sheet Page 6 of 26



02-04-2013

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013 FORM APPROVED

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	PROVIDER OR SUPPLIER I MEMORIAL NURSING	G HOME & REHAB CENTER		8	REET AUDRESS, CITY, STATE, ZIP CODE 186 HWY 411 NORTH ETOWAH, TN 37331	<u> </u>	1072013
(X4) ID PREFIX TAG	! (EACH DENCIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	residents (#95, #59, thirty-seven resident The findings include Resident #82 was at October 25, 2012, w Senile Delusion, Voll Renal Fallure. Medical record reviet dated November 6, 2 list-time with family, the Medical record reviet on November 9, 201 activities. Observation on January the Director of Nursing television on a countried the care placed the resident television on January the Director of Nursing television on a countried the care placed the car	or smoking, and three #52) for discharge plans of is reviewed. d: d: d: dimitted to the facility on ith diagnoses including, ume Depletion, and Acute w of the activity assessment 2012, revealed, "interest movies (oldies), likes pets" w of the care plan updated 2, revealed no care plan for ary 9, 2013, at 9:25 a.m., I lying on a low bed with the ry music station. 9, 2013, at 11:00 a.m., with an old not include activities. mitted to the facility on May es including Peripheral pertension, and Dementia of the Minimum Data Set 25, 2012, revealed "very avorite activity" and the	F2		1) An Activities Plan was added to the plans of Residents #82 and #60 by the Activity Director on 1/9/2013. The care plan of Resident #22 was upon 1/10/2013 to include smoking go approaches. Care plans for Residents #95, #59 and were reviewed and updated on 1/9/2013 to include discharge goals and interventions. 2) All residents currently in the facility future admission have the potential affected by this practice. 3) All interdisciplinary care plan team members responsible for writing care were be re-educated on the facility's and procedure for developing and up Comprehensive Care Plans on 1/16/2 all staff will attend a mandatory form service on 2/5-2/6/2013. 4) Care plans will be reviewed weekly accordance with the care plan review schedule by the MDS Coordinator(s) all the condition of the resident or attrequest of the resident (or resident's the Director of Nursing or designee, we complete random weekly audits of castor six (6) consecutive weeks. Random will be completed to ensure that comprehensive care plans are developed to the complete of the reviewed by the committee quarterly.	pdated als and d #52 2013 plans, ty and to be e plans policy dating 1013 and al in- / in / and the care changes the POA). will re plan 1 audits ped for	2/8/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IP6T11

Facility ID: TN5403

If continuation sheet Page 7 of 26

Robert & Polsker

02:49:02 p.m.

10/31

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) N A. BU		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		445277	B. WING			01/10/2013	
	ROVIDER OR SUPPLIER MEMORIAL NURSIN	G HOME & REHAB CENTER		E	REET ADDRESS, CITY, STATE, 2IP CODE 886 HWY 411 NORTH ETOWAH, TN 37331		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ŲLD BE	(X5) COMPLETION DATE
	November 21, 2012 activities of choice of Medical record reviet November 23, 2012 activities. Observation on Januar the resident's room, in a chair. Interview on Januar the Activity Director, Station, confirmed the include activities. Resident #22 was a August 19, 2011, and 2011, with diagnose Senite Dementia with Medical record reviet dated January 1, 20, 2013, revealed "Station, confirmed the resident designated smoking interview with the Di January 10, 2013, at Nurse's Station, confirmed the resident designated with the Di January 10, 2013, at Nurse's Station, confirmed the resident confirmed the resident designated smoking interview with the Di January 10, 2013, at Nurse's Station, confirmed the resident confirmed the resident designated smoking interview with the Di January 10, 2013, at Nurse's Station, confirmed the resident designated smoking interview with the Di January 10, 2013, at Nurse's Station, confirmed the resident designated smoking interview with the Di January 10, 2013, at Nurse's Station, confirmed the resident designated smoking interview with the Di January 10, 2013, at Nurse's Station, confirmed the resident designated smoking interview with the Di January 10, 2013, at Nurse's Station, confirmed the resident designated smoking interview with the Di January 10, 2013, at Nurse's Station, confirmed the resident designated smoking interview with the Di January 10, 2013, at Nurse's Station, confirmed the resident designated smoking interview with the Di January 10, 2013, at Nurse's Station, confirmed the resident designated smoking interview with the Di January 10, 2013, at Nurse's Station, confirmed the resident designated smoking interview desi	especially bingo/music" ew of the Care Plan updated the care Plan updated the resident sitting the B-Wing Nurse's the current care plan did not dreadmitted to the facility on dreadmitted on Dacember 1, is including Hyperiension.	F	279			

FORM CMS-2567(92-99) Pravious Versions Obsoleta

Event ID: IP6T11

Facility ID: TN5403

If continuation sheet Page 8 of 28

Robert & Polehan

DEPAR <u>CE</u> NTE	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 01/24/2013 MAPPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE:	
	· 	445277	B. WING		01/	10/2013
	PROVIDER OR SUPPLIER MEMORIAL NURSIN	G HOME & REHAB CENTER	888	ET ADDRESS, GITY, STATE, ZIP CO 3 HWY 411 NORTH OWAH, TN 37331		10/2013
(X4) ID PREFIX TAG	i (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECECED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 8	F 279			
	August 18, 2012, wi	idmitted to the facility on th diagnoses including alized Weakness, and				
	Data Set (MDS) dat revealed the resider on the Brief Intervie	ew of the quarterly Minimum ed November 26, 2012, at scored a fourteen of fifteen w for Mental Status (BiMS) skills and an active discharge community.				
;	dated August 24, 20 like resident in Floric	ew of a Social Work Note 12, revealed "family would daSocial Worker to work ain Medicare and transfer to				
	Medical record revie November 26, 2012 related to the reside	w of the Care Plan dated , revealed no documentation nts discharge plans.				
	January 9, 2013, at	ocial Service Director on 12:35 p.m., in the Social dirmed the Care Plan dated did not address the plan.				
	November 9, 2012, 1 Congestive Heart Fa	dmitted to the facility on with diagnoses including tilure, Displaced Right Hip ack Pain, Lumbar Spine and Hypertension.	William to the second s			
i	dated January 10, 2(w of Physician's Order Sheet, 013, revealed the resident d home on January 15, 2013.				

FORM CMS-2567(02-99) Previous Versions Obsolele

Event ID: IP6T11

Facility ID: TN5403

If continuation sheat Page 9 of 28

Robert & Polohan

02:49:36 p.m.

02-04-2013

If continuation sheet Page 10 of 28

12/31

DEPAR CENTE	RTMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 01/24/201 MAPPROVE	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY LETED	
		445277	B. WING_		na.	1/10/2013	
	PROVIDER OR SUPPLIER V MEMORIAL NURSIN	G HOME & REHAB CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 886 HWY 411 NORTH ETOWAH, TN 37331	1 017	10/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDAF	(X5) COMPLETION DATE	
F 279	Continued From pa	ge 9	F 279				
	November 27, 2012	ew of the Care Plan, dated , revealed no documentation nt's impending discharge.					
	i the nursing station.	y 10, 2013, at 12:27 p.m., at with the Director of Nursing, Plan did not address the glascharge.					
	October 8, 2012, wit	eadmitted to the facility on h diagnoses including Acute plegia, and Pressure Ulcer.				•	
	Medical record revie discharged to anothe November 21, 2012.	w revealed the resident was er nursing facility on					
	Medical record revie October 21, 2012, re related to the resider	w of the Care Plan dated vealed no documentation nt's discharge needs.					
F 280	confirmed the Care f dld not address the r 483.20(d)(3), 483.10	10, 2013, at 9:45 a.m., with ng, in the private dining room, Plan dated October 21, 2012, esident's discharge needs. (k)(2) RIGHT TO NING CARE-REVISE CP	F 280				
	incompetent or other incapacitated under t	he laws of the State, to					
i '	Within 7 days after the	e plan must be developed e completion of the essment; prepared by an					
M CM5-266	7(02-88) Previous Versions O	bsolete Event ID; IP6T11		ity ID: TN5403		Data 4D of 90	

Robert Stolation

Facility ID: TN5403

02:49:53 p.m. 02-04-2013

13 /31

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
·		445277	B. WING		01/10/2013	
	ROVIDER OR SUPPLIER I MEMORIAL NURSIN	G HOME & REHAB CENTER	s	TREET ADDRESS, CITY, STATE, ZIP CODE 886 HWY 411 NORTH ETOWAH, TN 37331		·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	interdisciplinary tear physician, a register for the resident, and disciplines as deterr and, to the extent pr the resident, the res legal representative, and revised by a tea each assessment. This REQUIREMEN by: Based on medical re and interview, the fa plan for the use of si update the care plan for one (#63) of thirty The findings included Resident #82 was ac October 25, 2012, w Senile Delusion, Volu Renal Failure. Medical record review on November 9, 201; lowest position, upper repositioning" Observation on Janu revealed the resident 1/4 sideralis in the ra	m, that includes the attending red nurse with responsibility other appropriate staff in mined by the resident's needs, recticable, the participation of ident's family or the resident's rand periodically reviewed im of qualified persons after. T is not met as evidenced ecord review, observation, cility falled to update the care derails for one (#82), failed to related to a pressure ulcer y-seven residents reviewed, d: Imitted to the facility on ith diagnoses including, ame Depletion, and Acute w of the Care Plan updated 2, revealed, "Keep bed in a ralis for assistance with any 7, 2013, at 3:56 p.m., tying on a low bed with four	F 28		e of four Iternating 13 the ated to ag in a to be e need for 5/2013 C care and I lans daily ensure been ing the sing or ple of care eks to are plans.	2/8/2013
	7100 cm c					

FORM CMS-2587(02-99) Previous Versions Obsolela

Event ID: IP6T11

Facility ID: TN5403

If continuation sheet Page 11 of 26

Robert BPolsher

02:50:15 p.m.

14/31

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT	T OF DEFICIENCIES	Att. Challenger and an arrival	1				. 0930-0391
AND PLAN	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DPLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445277	B. WII	NG_		01/1	0/2013
NAME OF F	PROVIDER OR SUPPLIER			511	REET ADDRESS, CITY, STATE, ZIP CODE		
MCMINN		G HOME & REHAB CENTER		8	886 HWY 411 NORTH ETOWAH, TN 37331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	the nursing station, confirmed the Care reflect the use of for Resident # 63 was a 9, 2008, and readm November 17, 2012 Diabetes Mellitus, C Generalized Muscle Medical record revise December 20, 2012 evidenced by suspe buttocksapply skir Medical record revise dated December 18 (discontinue) calmos (left) buttock begin s (twice dally) until hei Medical record revise December 29, 2012 buttock area with w/Neosporin ointment, q (every) 3 days" Observation on Januthe resident's room, had become two sephad opened. Interview with the Die 9, 2013, at 2:00 p.m. Station, confirmed the	with the Director of Nursing, Plan was not updated to ur siderails. admitted to the facility on June lited to the facility on , with diagnoses including callulitis Left Heel, and weakness. aw of the Care Plan dated , revealed "Impaired skin as ceted deep tissue injury to n prep to buttock" aw of a Physician's Order , 2012, revealed "D/C septine tx (treatment) to L skin prep to L buttock bid	F	280	F		
	pressure ulcer.	_					
F 314	483.25(c) TREATME	101/5008 10	F3	14		ļ	ļ
	7/00 001 0					<u>.</u>	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; IP6T11

Facility ID: TN5403

If continuation sheet Page 12 of 26

Robert to Palabar

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

CTATELITAT	T OF DEPLETE:	STATE OF THE OF TARES				OWR NO	<u>. 0938-0391</u>
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF S		445277	B. WD	4G _		01/1	10/2013
MCMINN		G HOME & REHAB CENTER		8	REET ADDRESS, CITY, STATE, 2IP CODE 86 HWY 411 NORTH ETOWAH, TN 37331		
(X4) ID PREFIX TAG	! (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
SS=D	resident, the facility who enters the facility does not develop prindividual's clinical of they were unavoidal pressure sores recessives to promote prevent new sores for this REQUIREMENT by: Based on medical review of facility polifalled to assess a prindividual falled to assess a principal falled to ass	rehensive assessment of a must ensure that a resident ty without pressure sores essure sores unless the condition demonstrates that ple; and a resident having fives necessary treatment and healing, prevent infection and rom developing. T is not met as evidenced ecord review, observation, cy, and interview, the facility essure ulcer for one resident residents reviewed. d: Imitted to the facility on June that to the facility on with diagnoses including ellulitis Left Heel, and Weakness. w of the Minimum Data Set ber 11, 2012, revealed the or developing pressure ageable pressure ulcer tensive assist for bed	F3	314	1) On 1/9/2013 the RN Charge Nurse Physical Therapy Assistant conduct wound assessment on Resident #63 the opened area in the Deep Tiss. At this time, the wound was material staged and reported to the particular to the particular to the particular to the particular to plans by the ADON to reflect all pressure ulcer interventions. The reviewed the revised care plans with involved in the care of the residents with wounds could plan to the particular to the par	ed a skin/ to stage ue Injury. neasured, ordered. othe care Il current e ADON h all staff ident on	2/8/2013

FORM CMS-2567(02-99) Previous Versions Obscieta

Event ID: IP6T11

Facility ID: YN5403

If continuation sheet Page 13 of 26

Robert BRolchan

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

						CIND MO.	0930-0381	
AND PLAN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	(X3) DATE SURVEY COMPLETED	
		445277	B. WII	NG_		01/1	0/2013	
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
MCMINN	MEMORIAL NURSIN	G HOME & REHAB CENTER		8	986 HWY 411 NORTH STOWAH, TN 37331			
(X4) ID PREFIX TAG	! (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLO BE	(X5) COMPLETION DATE	
F 314	Continued From particles open now" Medical record revision of particles open now" Medical record revision of particles open now" Medical record revision of particles open now Medical record revision of particles open now Medical record revision of twice daily) until here. Medical record revision of particles open of note of now Medical record revision of particles open of note open open open open open open open ope	ge 13 ew of the Care Plan dated c, revealed "Impaired skin as ected deep tissue injury to n prep to buttock" ew of a Physician's Order , 2012, revealed "D/C septine tx (treatment) to L skin prep to L buttock bid aled" ew of a Physician Order dated , revealed "cleanse L c (wound cleaner) apply cover with aquacel, change ew of the Pressure Ulcer rry 9, 2013, revealed III pressure ulcer on eary 9, 2013, at 1:32 p.m., in revealed the pressure ulcer parate wounds and the areas icy, Skin Care Assessment ention, dated September 1, bund will be measured and event of a change" rector of Nursing on January	TAG	314	CROSS-REFERENCED TO THE APPR DEFICIENCY)	opriate sure Ulcer riging was le injuries and any and any anserviced to review lts, skin plans on day, inimum of for three thereafter an PI/QA	DATE	
	Station, confirmed th	, at the B-Wing Nurse's e facility falled to stage the it opened on December 18,						

FORM CMS-2567(B2-99) Previous Versions Obsoleta

Event ID: IP6T11

Facility ID: TN5403

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Robert Blobahan

02:51:13 p.m. 02-04-2013

17/31

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/24/2013 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL1A IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445277 01/10/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MCMINN MEMORIAL NURSING HOME & REHAB CENTER 886 HWY 411 NORTH **ETOWAH, TN 37331** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 314 Continued From page 14 F 314 2012. F 323 483.25(h) FREE OF ACCIDENT F 323 SS=E | HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, review of Material Safety Data Sheets, and Interview, the facility falled to follow the fcaility's smaking policy for one resident (#22) and to ensure the residents environment remained free of accident hazards on one of two hallways. The findings included: Resident #22 was admitted to the facility on August 19, 2011, and readmitted on December 1,

FORM CMS-2567(02-99) Previous Versions Obsolete

Evan(ID: (P6T1)

Facility ID: TN5403

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Robert Blobaban

2011, with diagnoses including Hypertension and

Medical record review of the Physician Orders dated January 1, 2013 through January 31, 2013, revealed "...Smokes w (with)/ supervision..."

Observation on January 7, 2013, at 2:00 p.m., revealed the resident sitting in an electric wheelchair at the door on B-Wing. Continued observation at this time revealed two cigars in the

Senile Dementia with Delusions.

02-04-2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/24/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445277 01/10/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 886 HWY 411 NORTH MCMINN MEMORIAL NURSING HOME & REHAB CENTER ETOWAH, TN 37331 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY Continued From page 15 1) Appropriate revisions were made to the F 323 care plan on 1/8/2013 to reflect the Resident cup holder attached to the electric wheelchair. #22 being able to smoke cigars and/or chew 2/8/2013 cigars. The DON spoke with the resident on Observation on January 7, 2013, at 2:15 p.m., revealed the resident outside smoking in the 1/8/2013 regarding the storage of his cigars in designated smoking area with supervision. the smoke box instead of his cup on the mobility chair. On 1/9/2013 the DON spoke Continued observation revealed the resident attempted to put the cigar out and another with the resident son regarding the resident's resident assisted. Further observation at this cigars to be stored in the smoke box instead time revealed a staff member approached the of in the possession of the resident per facility residents, assisted resident #22 in putting the cigar out, placed the cigar in the cup holder of the 2) All other residents who currently smoke electric wheelchair and the resident entered the could be affected by this practice. facility. 3) All smoking materials for all residents who desired to smoke or chew are stored in a Observation on January 8, 2013, at 9:00 a.m., in secure box in the nursing station. Residents the dining room, revealed the resident in the will only have access to smoking materials electric wheelchair and two clgars in the cup during supervised smoke periods. A smoking holder of the electric wheelchair. assessment was completed for all residents who smoke on 1/23/2013. All staff will be Observation on January 10, 2013, at 7:45 a.m., in reeducated on the facility smoking policy and the dining room, revealed the resident in the smoke assessment forms at the mandatory electric wheelchair and two cigars in the cup staff meeting on 2/5/2013 and 2/6/2013. holder of the electric wheelchair. 4) The nursing home leadership team will Review of facility policy, Resident Smoking. review any requested changes or new effective date March 1, 2005, revealed "...All requests by residents prior to approving the residents who smoke will be individually assessed use of tobacco. The decision will be made a by the Care Plan Team...This will be documented part of the residents care plan. on the Care Plan and put on the resident's chart...All smoking paraphernalia will be stored...by the staff...staff will keep all smoking paraphemalia until the designated smoking times..."

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Event ID: IP6T11

FedRty ID: TN5403

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Interview with Director of Nursing (DON) on January 10, 2013, at 8:48 a.m., in the B-Wing

Nurse's Station, revealed no smoking assessment had been completed and the

02-04-2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/24/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445277 01/10/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MCMINN MEMORIAL NURSING HOME & REHAB CENTER 886 HWY 411 NORTH ETOWAH, TN 37331 (X4) (D SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) F 323 | Continued From page 16 F 323 resident had been allowed to keep the cigars in The automatic door closer to the "A" the resident's cup holder of the electric Wing housekeeping closet was repaired wheelchair. Further interview at this time 2/8/2013 on 1/8/2013 by the nursing home confirmed the facility failed to follow the facility's maintenance Department. There were no policy and procedure for resident Smoking. residents harmed. 2) Any resident who is mobile in the Observation on January 7, 2013, at 12:42 р.т., in nursing home had the potential to be the A-Wing housekeeping closet, revealed the affected by the housekeeping closet door door standing open and a sign on the door revealed "...keep door tocked..." Further being open. observation at this time revealed six quarts of tile 3) The nursing home maintenance Department will make a visual check of grout protector (sealer), one quart of Virex (disinfectant), one quart of activate (enzyme door closers quarterly and make the presoak), one twelve ounce bottle of fire and ant appropriate repair. All nursing home staff killer (pesticide) one half full, one quart glass jar on duty were reeducated to check that labeled 7 dust (pesticide) one fourth full, one cabinet and closet doors are locked and gallon water seal (water proofing sealer) one half closed. This directive will be repeated to full, one sixteen ounce plastic bottle of resolve all staff during the mandatory staff (carpet cleaner) one half full, two gallons of Mean

Review of the Material Safety Data Sheets (MSDS) revealed:

bottle of Lysol (disinfectant).

1) Tile grout protector revealed "...Health Effects: May be harmful if inhaled...avoid eve contact...Keep out of reach of children ... " 2) Virex "...Hazards identification: Harmful or fatal if swallowed...Keep out of reach of children..." 3) Activate "...can irritate nose, throat, and lungs...keep out of reach of children..." 4) Fire and ant killer "...may be harmful if absorbed through skin...keep out of reach of

Green (all purpose cleaner), and a twelve ounce

- children..." 5) Seven dust "...Hazardous to humans...if swallowed...keep out of reach of children..."
- 6) Water seal "...may cause headache, nausea. or dizziness...keep out of reach of children..."

- meetings on 2/5 and 2/6/2013.
- 4) The nursing home administrator and DON will review the reports from maintenance and make a visual inspection during periodic rounds (M - F) in the nursing home. Staff will be instructed at the staff meeting to close and lock doors and report defective closers to the nursing home maintenance department by completing a work order slip and informing either the nursing home administrator or the DON. All staff are responsible to ensure that all cabinets and closet doors are locked and closed.

FORM CMS-2567(02-99) Pravious Versions Obsolete

Event ID: JP6T11

Facility ID: TN5403

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Robert & Polekan

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARE SERVICES

PRINTED: 01/24/2013 FORM APPROVED OMB NO 0938-0391

		& MEDICAID SERVICES	 .			OMB NO	<u>. 0938-0391</u>
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		445277	B. WII	NG_		01/1	10/2013
NAME OF F	PROVIDER OR SUPPLIER	-	_	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MCMINN	MEMORIAL NURSIN	G HOME & REHAB CENTER		{	886 HWY 411 NORTH ETOWAH, TN 37331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	JLD BE	(X5) COMPLETION DATE
	7) Resolve "avoid of reach of children. 8) Mean green "ke 9) Lysol "keep out Observation and into 12:55 p.m., in the housekeeping of the housekeeping of 483.25(I) DRUG RE UNNECESSARY DE Each resident's drug unnecessary drugs. drug when used in a duplicate therapy); o without adequate moundications for its use adverse consequents should be reduced a combinations of the Based on a comprehesident, the facility resident, the facility rewho have not used a given these drugs untherapy is necessary as diagnosed and do record; and residents drugs receive graduate behavioral interventions.	contact with eyeskeep out" eep out of reach of children" of reach of children" erview on January 7, 2013, at busekeeping closet, with the med the chemicals and e not in a locked cabinet and loset should be locked. GIMEN IS FREE FROM RUGS regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or enitoring; or without adequate e; or in the presence of ess which indicate the dose or discontinued; or any reasons above. tensive assessment of a must ensure that residents intipsychotic drugs are not alless antipsychotic drug to treat a specific condition for the clinical se who use antipsychotic all dose reductions, and		323			
				ŀ			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IPST11

Facility ID: TN5403

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Robert & Polcha

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

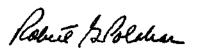
STATEMENT	OF DEFICIENCIES	(V1) PROMOFERICIAN ISSUE					<u>. 0936-0391</u>	
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU		IPLE CONSTRUCTION	(X3) DATE 8 COMPL) DATE SURVEY COMPLETED	
		445277	B. Wit	NG_		01/1	0/2013	
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		D/LU IU	
MCMINN	MEMORIAL NURSIN	G HOME & REHAB CENTER		8	86 HWY 411 NORTH ETOWAH, TN 37331			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOWN GROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	This REQUIREMENT by: Based on medical repolicy, and interview unnecessary medical one resident (#36) or reviewed. The findings include Resident #36 was a September 9, 2008, 2012, with diagnose Failure, Pleural Effur Pulmonary Disease. Medical record review Normalization Ratio clotting) dated Dece 23.0 (normal range range .80-1.20). Medical record review December 24, 2012, results to DR. (doctor Medical record review Administration Record 2012 through December 24, 2012, results through December 24,	record review, review of facility to the facility falled to ensure ations were administered for of thirty-seven residents. Id: Id: Id: Id: Id: Id: Id: Id: Id: Id	F		1) The order for the m prescribed to Resident #36 was by the physician. A PT/IN completed Resident #36 on The physician was notified prompreceiving the results of the resid INR which was within the the range. 2) The facility has determined the residents taking Coumadin therapt the potential to be affected. 3) LPN #1 was counseled on 1/8/2 the DON addressing the circumst that require notification of the residents require notification of the residents. This included notification holidays and off hours and the coprotocol which included to hold cowhen INR is high until new orders received from the physician. All cinurses responsible for medication administration currently working heen individually reeducated about notification of the resident's physicianal representative or family menincluding notification during holidation for the therapeutic INR is higher that the therapeutic	IR was 1/7/2013. pily upon ent's PT/ erapeutic It all by had I/2013 by eances ident's family in during umadin burnadin eare harge it clan, inber itys and when the range.	2/8/2013	
	(anticoagulent) 4 mg December 25, 2012, given to the resident Medical record revie December 26, 2012,	had been given, and on (Tuesday) 2 mg had been			An in-service concerning this issu conducted by the DON on 2/5/2012/6/2013 during the mandatory stameetings. All PRN and charge nurleave will be in-serviced upon retuwork. Continues on the next page.	13 and aff rses on 1		

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Event ID: IP6711

Facility ID: TN5403

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/24/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445277 01/10/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MCMINN MEMORIAL NURSING HOME & REHAB CENTER 886 HWY 411 NORTH **ETOWAH, TN 37331** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION 1D PREFIX PREFIX TAG TAG DATE DEFICIENCY) F 329 | Continued From page 19 F 329 (Saturday), Tue (Tuesday), Thur (Thursday), 4 mg all other days..." Continued from the previous page 4) The DON or designee, will Medical record review of a PT/INR dated conduct a random audit of five (5) December 30, 2012, revealed PT 26.4 and INR residents that take Coumadin 3.9.

Medical record review of a Nurse's Note dated December 31, 2012, revealed *...Protime faxed to DR..."

Medical record review of the MAR dated December 1, 2012 through December 31, 2012, revealed on December 31, 2012, (MONDAY) Coumadin 4 mg had been given to the resident.

Medical record review of the MAR dated January 1, 2013 through January 31, 2013, revealed on January 1, 2012, (MONDAY) Coumadin 4 mg had been given to the resident.

Medical record review of a Nurse's Note dated January 2, 2013, revealed "...orders received for Coumadin dosage and frequency. Hold Coumadin X (times) 2 doses 1/2 and 1/3/13. Restart 4 mg M (Monday), W (Wednesday), F (Friday), and 2 mg T (Tuesday), TH (Thursday), Sa (Saturday) Su (Sunday)...

Review of facility policy, Anticoagulation Therapy, dated December 22, 2011, revealed "...if lab results exceed therapeutic range, the facility will "Hold" the anticoagulant medications until the physician has been notified and new order is received..."

Interview with Licensed Practical Nurse (LPN) #1 (responsible for administration and notification of

weekly for four (4) consecutive weeks. Unit Managers will continue to audit M-F all Coumadin flow sheets and report discrepancies to the DON. Results of the audits will be reported at the quarterly PT/QA committee meetings.

FORM CMS-2567(02-99) Pravious Versions Obsoleta

Event ID: IPST11

Facility ID: TN5403

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Robert Blolation

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013 FORM APPROVED

STATEMEN	IT OF DEFICIENCIES	WAY THE PROPERTY OF THE PROPER				OMR NO). 0938-03 <u>91</u>
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING		(X3) DATE 9 COMPL	
		445277	B. WIN	.G		01/-	10/2013
MCMINI		g home & rehab center		STREET ADDRESS, CITY, 1 886 HWY 411 NORTH ETOWAH, TN 3733			
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION SHOPE ENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 333 SS=D	at the B-Wing Nurse Coumadin 2 mg had 24, Coumadin 4 mg December 25, Cour on 31, 2012, and Co on January 1, 2013. Interview with the Di 8, 2013, at 4:00 p.m Station, confirmed the anticoagulation med resident received the December 24, and 2 Coumadin on December 1, 2013. 483.25(m)(2) RESID SIGNIFICANT MED The facility must ensany significant medicated as a significant medicated (#36) of thirty-seven The findings included Resident #36 was ad September 9, 2008, 2012, with diagnoses	anuary 8, 2013, at 4:00 p.m., e's Station, revealed to been given on December I had been given on madin 4 mg had been given burnedin 2 mg had been given burnedin for four days and the elecation for four days and January bents FREE OF ERRORS Sure that residents are free of cation errors. This not met as evidenced ecord review, review of facility the facility falled to prevent ion error for one resident residents reviewed.	F 3				

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Robert plolelian

02-04-2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SI COMPLE	(X3) DATE SURVEY COMPLETED	
		445277	B. WII	VG_		01/1	0/2013	
	ROVIDER OR SUPPLIER	G HOME & REHAB CENTER		8	REET ADDRESS, CITY, STATE, ZIP CODE 86 HWY 411 NORTH RTOWAH, TN 37331			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLO BE	(X5) COMPLETION DATE	
	Medical record reviews and all other days" Medical record reviews and all other days" Medical record reviews administration Record through December 24, 2012 and a medical record reviews administration Record through December 24, 2012 (anticoagulant) 4 medical record reviews and all other days" Medical record reviews all other days"	ew of a Protime/International (PT/INR) (lab test for blood ember 24, 2012, revealed PT 10-13), and INR 3.0 (normal ew of a Nurse's Note dated revealed "faxed Protime or)" ew of the Medication ord (MAR) dated December 1, mber 31, 2012, revealed on red (MONDAY) Coumadin g had been given, and on red (Monday) 2 mg had been red at 3:30 p.m., revealed din 2 mg (milligrams) Sat asday), Thur (Thursday), 4 revealed PT 26.4 and INR revealed PT 26.4 and INR revealed "Protime faxed to w of the Medication red (MAR) dated December 1, mber 31, 2012, revealed on red (MAR) dated December 1, mber 31, 2012, revealed on red (MONDAY) Coumadin 4 mg	F	333 	1) The order for the medication posteron to Resident #36 was reviewed physician. A PT/INR was compressed to the resident #36 on 1/7/2013. The was notified promptly upon receptures of the resident's PT/INR was within the therapeutic range. 2) The facility has determined that residents taking Coumadin therapeutic potential to be affected. 3) LPN #1 was counseled on 1/8/2 addressing the circumstances that notification of the resident's physical representative or family mentification of the resident's physical representative or family mentification during heard off hours and the holding of Cowhen the INR is out of normal range charge nurses currently working a responsible for medication administration of the resident's physical representative or family mentification during holidation administration of the resident's physical representative or family mentification during holidation du	d by the bleted for physician siving the which was tall by had 2013 trequire cian, ber. colldays coumadings. All stration labout clan, ber ys and adin ses ed upon fuct a and Jnit Fall cof the	2/8/2013	

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Event ID: IP6T11

Facility ID: TN5403

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Robert Golden

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		445277	B. WING _		01/10	0/2013
	ROVIDER OR SUPPLIER MEMORIAL NURSIN	G HOME & REHAB CENTER	8:	EET ADDRESS, CITY, STATE, ZIP CODE 86 HWY 411 NORTH TOWAH, TN 37331		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO GROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	COMPLETION DATE
F 333	1, 2013 through Ja January 1, 2012, (Note of provided in the results of particular to the physician force of particular to the physician of particular to particular the particular to particular to particular to particular to particular to the particular to the particular to particular to the	ew of the MAR dated January nuary 31, 2013, revealed MONDAY) Cournadin 4 mg had esident. ew of a Nurse's Note dated exealed "orders received for and frequency. Hold by 2 doses 1/2 and 1/3/13. Conday), W (Wednesday), F T (Tuesday), TH (Thursday), Sunday)" policy, Anticoagulation comber 22, 2011, revealed eed therapeutic range, the see anticoagulant medications has been notified and new " made Practical Nurse (LPN) #1 ministration and notification of anuary 8, 2013, at 4:00 p.m., se's Station, revealed deen given on madin 4 mg had been given 2012, and Cournadin 2 mg had	F 333			

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Event ID: IP6T11

Facility ID: TN5403

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Pobut Globalian

02:54:13 p.m.

26/31

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLI		(X3) DATE SU COMPLET	RVEY red
		445277	B. WO	₩ <u></u>		01/10	/2013
	ROVIDER OR SUPPLIER MEMORIAL NURSIN	G HOME & REHAB CENTER		88	EET ADDRESS, CITY, STATE, ZIP CODE 86 HWY 411 NORTH TOWAH, TN 37331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and of to help prevent the of disease and infection Control The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what pr should be applied to (3) Maintains a recording service (4) Preventing Spread (5) Preventing Spread (6) Preventing Spread (7) When the Infective determines that an prevent the spread isolate the resident (8) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each d hand washing is interpreted in the control (6) Linens Personnel must ha	of Program stablish an Infection Control ich it - introls, and prevents infections recedures, such as isolation, o an individual resident; and ord of incidents and corrective infections. The properties of infection tion Control Program esident needs isolation to of infection, the facility must it prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	F	441			
	1		ı				l

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Event ID: IP6T11

Facility ID: TN5403

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Robert & Molelian

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEN/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		· · · · ·	B. WIN		<u></u> _		
		445277	10			01/10)/2013
	ROVIDER OR SUPPLIER MEMORIAL NURSIN	G HOME & REHAB CENTER		8	EET ADDRESS, CITY, STATE, ZIP CODE 86 HWY 411 NORTH TOWAH, TN 37331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	by: Based on medical review, observation failed to ensure informal maintained for one reviewed. The findings include Resident #27 was a December 26, 2012 Diabetes, Hyperten Dementia with Behamedical record revidated January 1, 20 (Intravenous needle Medical record revidanuary 1, 2013, re (Intravenous needle hand" Review of facility post facility	record review, facility policy and interview, the facility action control practices were (#27) of thirty-seven residents ed: admitted to the facility on 2, with diagnoses including sion, Fractured Femur, avior, and Bipolar Disorder. ew of a Physician's Order 013, revealed "Start INT e)" ew of a Nurse's Note dated evealed "placed IV e)cath (catheter) in (right) policy, Insertion and Intermittent infusion Device, eripheral INT device shall be	F4	41	1) The nurse identified as R Nurse #1 was Immediately reedithe proper procedures and factor into insertion, removal and checklists our facility has determined residents requiring into hotential to be affected. 3) All licensed nursing staff was eviced 2/5/2013 and 2/6/2015 and 2/6/2015 and 2/6/2015 and Guideline. An in-service and revint policy and procedure will be to PRN nurses and nurses on learn to work. 4) The DON or designee, will random Validation Checklists with an INT to nurses are practicing in accordant facility's Practice Guideline resident's physician order and a Validation Checklists will be revited PI/QA Committee.	ucated on lity policy anging. I that all ave the vill be in- ill be in- ill on the Practice lew of the provided eave upon complete of nurses o ensure ance with and the care plan.	2/8/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Robert & Polaha

Event ID: IP6T11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 01/24/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A		PI.E CONSTRUCTION IS	(X3) DATE SI COMPLE	(X3) DATE SURVEY COMPLETED	
		445277	B. WI	NG_		01/1	0/2013	
	PROVIDER OR SUPPLIER I MEMORIAL NURSIN	G HOME & REHAB CENTER		8.	REET ADDRESS, CITY, STATE, ZIP CODE 86 HWY 411 NORTH TOWAH, TN 37331			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 441	Interview on Januar the Director of Nurs	ge 25 changed per facility policy. y 10, 2013, at 8:45 a.m., with ing, at the nurse's station, y was not followed for the INT	F	441				

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Event (0:)P6T11

Facility ID: TN5403

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Robert & Politica